Example of Plan of Care for Case 2

(ANNUAL CERTIFICATION DUE) PCS - 11/1/04

DMA-3000
(REV 2/93)

CC-010-89

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
PERSONAL CARE SERVICES (PCS) PHYSICIAN AUTHORIZATION AND PLAN OF CARE Case 2

✓ INITIAL ASSESSMENT (REFERRAL DATE 11-4-03) ____ REASSESSMENT

Best Care, Inc (PROVIDER AGENCY) | Anytown, NC (CITY/TOWN) | (XXX) XXX-XXXX (PHONE)

PATIENT INFORMATION

1. NAME Stella Smith — 2. MEDICAID NO. XXX - client #
3. ADDRESS 101 Dairy Lane, Anytown, NC
4. PHONE (XXX) XXX-XXXX — 5. SEX: ____ MALE ✓ FEMALE — 6. DOB 10/21/27
7. LIVES: ____ ALONE ____ W / SPOUSE ✓ W / ADULT CHILD(REN) ____ W / PARENT(S) ____ W / OTHERS
8. CONTACT PERSON: NAME Stan Smith — RELATIONSHIP son.
ADDRESS 101 Dairy Lane, Anytown, NC. — PHONE (H) XXX-XXX-XXXX (W) XXX XXXX
9. ATTENDING PHYSICIAN: NAME Dr Daniel Jones — PHONE XXX-XXX-XXXX
ADDRESS 222 Near Hospital St. Anytown, NC
DATE OF MOST RECENT EXAMINATION 10/16/03
10. REASON FOR REFERRAL needs help c personal care - long term, peg
11. DIAGNOSIS (DATE OF ONSET) CVA c swallowing deficit - 2002; insertion peg for feeding 10/03;
CVA c (R) sided Weakness - 97, HTN - 10 yrs

12. CURRENT CARE-TYPE AND SOURCE
Home Health - RN and aide services

EVALUATION

13. MEDICATIONS - NAME/DOSE/FREQUENCY/ROUTE
HCTZ 25mg po/per peg q am
Lanoxin 0.125 mg po/per peg q am.
Coumadin 2.5 mg po/per peg at supper - 6 pm.
Multivitamin 1 po/per peg - crushed q am.
Tylenol 325 mg 1 or 2 po/per peg prn pain

SELF-ADMINISTERED? (Y / N) N — IF "N", WHO ASSISTS (NAME / RELATIONSHIP) daughter in law

14. AMBULATION: ____ NO PROBLEMS ____ LIMITED ABILITY ____ AMBULATORY W/ AID OR DEVICES ✓ NON-AMBULATORY
DEVICES/ASSISTANCE NEEDED transfer to chair, BSC.
15. NUTRITION: ____ ORAL ____ PARENTERAL ✓ TUBE (TYPE PEG; Ensure plus @ can/day.
DIETARY RESTRICTIONS: NPO
16. RESPIRATION: ✓ NORMAL ____ TRACHEOSTOMY ____ MECHANICAL ____ OXYGEN ____ DYSPNEA
17. SKIN: ✓ NORMAL ____ PRESSURE AREAS ____ DECUBITI ____ OTHER peg site - wash daily.
SKIN CARE NEEDS at risk - skin breakdown due to immobility
18. BOWEL: ____ NORMAL ✓ OCCASIONAL INCONTINENCE (LESS THAN DAILY) ____ DAILY INCONTINENCE
____ OSTOMY: TYPE ____ SELF-CARE? (Y / N) N
19. BLADDER: ____ NORMAL ✓ OCCASIONAL INCONTINENCE (LESS THAN DAILY) ____ DAILY INCONTINENCE
____ CATHETER: TYPE ____ SELF-CARE (Y / N) N
20. ALLERGIES: PCN
21. ORIENTATION: ✓ ORIENTATED ____ SOMETIMES DISORIENTED ____ ALWAYS DISORIENTED
22. MEMORY: ____ ADEQUATE ✓ FORGETFUL-NEEDS REMINDERS ____ SIGNIFICANT LOSS-MUST BE DIRECTED
23. BEHAVIOR: ✓ COOPERATIVE ____ PASSIVE ____ PHYSICALLY ABUSIVE ____ VERBALLY ABUSIVE
____ WANDERS ____ INJURES SELF / OTHERS / PROPERTY ____ NON-RESPONSIVE
____ OTHER
24. VISION: ✓ ADEQUATE FOR DAILY ACTIVITIES ____ LIMITED (SEE LARGE OBJECTS) ____ VERY LIMITED (BLIND)
USES: ✓ GLASSES ____ CONTACT LENS
25. HEARING: ✓ ADEQUATE FOR DAILY ACTIVITIES ____ HEAR LOUD SOUNDS / VOICES ____ VERY LIMITED (DEAF)
____ USES HEARING AID
26. SPEECH: ____ NORMAL ✓ SLURRED ____ WEAK ____ OTHER IMPEDIMENT ____ NONE
27. COMMUNICATION METHOD: ✓ SPEECH ____ GESTURES ____ WRITING ____ NONE
____ ASSISTIVE DEVICE (TYPE ____
28. OVERALL MEDICAL CONDITION: IS PATIENT MEDICALLY STABLE ? (Y / N) Y
29. SPECIAL CARE NEEDS/COMMENTS
NA-2 Task: Tube feeding.

Smith, Stella Case 2

30. UNMET NEEDS: CHECK THE TASKS FOR WHICH THE PATIENT NEEDS ASSISTANCE DUE TO HIS/HER MEDICAL CONDITION AND THE NEED IS EITHER NOT MET OR INADEQUATELY MET. SHOW THE TYPE OF HELP NEEDED AND HOW OFTEN IT IS NEEDED.

TYPE HELP NEEDED / HOW OFTEN

PERSONAL CARE

- ✓ EATING: PEG / Ensure plus, NPO due to swallowing problems
- ✓ GROOMING: assist to dress, at each visit - hair, mouth care
- ✓ DRESSING: assist to dress
- ✓ BATHING: total bath - bed or ↑ to BSC.
- ✓ USE OF TOILET: total transfer to BSC; assist to clean
- ✓ TRANSFER: total transfer to BSC, chair, WC.
- AMBULATION
- MEAL PREPARATION: 0 - tube fed
- ✓ MEDICATION INTAKE: assist ∑ pre-pared meds.

INCIDENTAL HOME MANAGEMENT

- ✓ CLEANING: tidy bedroom, bathroom, wash BSC,
- ✓ LAUNDERING: when wet clothes / linen change
- ESSENTIAL SHOPPING: 0
- ✓ MAKE BED: daily,

31. ARE THERE SOURCES (FAMILY, FRIENDS, PROGRAMS, & AGENCIES) TO MEET ABOVE NEEDS? (Y / N) Y

IF "Y", IDENTIFY SOURCES AND WHICH NEEDS CAN BE MET

son / shopping ; Dtcr - pre-pors meds

PLAN OF CARE

32 IF THE EVALUATION INDICATES THE PATIENT HAS MEDICALLY-RELATED PERSONAL CARE NEEDS REQUIRING PCS, SHOW THE PLAN FOR PROVIDING CARE. LIST THE DAY(S) SERVICES ARE NEEDED; THE TASKS TO BE PERFORMED ON THOSE DAYS; AND THE TOTAL TIME NEEDED EACH DAY.

DAY OF WEEK	TASKS TO BE ACCOMPLISHED	TIME
M	Total bath, groom, dress, ↑ to BSC, tube feed, tidy BR / bathroom. linen change	4
T	Total bath, groom, dress, ↑ to BSC, tube feed, laundry	4
W	Total bath, groom, dress, ↑ to BSC, tube feed, vaccum.	4
Th	Total bath, groom, dress, ↑ to BSC, tube feed, linen change	4
Fr	Total bath, groom, dress, ↑ to BSC, tube feed, laundry	4

33. GOALS: NEED FOR PCS IS EXPECTED TO CHANGE / END (CIRCLE ONE) ON ___/___/___. IF NO CHANGE EXPECTED, STATE WHY: chronic illness with no improvement expected

NURSE ASSESSOR CERTIFICATION

I CERTIFY THAT I HAVE COMPLETED THE ABOVE EVALUATION OF THE PATIENT'S CONDITION.

✓ I FOUND THE PATIENT NEEDS PERSONAL CARE SERVICES DUE TO THE PATIENT'S MEDICAL CONDITION. I HAVE DEVELOPED THE PLAN OF CARE TO MEET THOSE NEEDS.

___ I FOUND THE PATIENT DOES NOT MEET THE CRITERIA FOR PERSONAL CARE SERVICES.

René Realnurse, RN (NAME) — René Realnurse, RN (SIGNATURE) — 11-7-03 (DATE)

PHYSICIAN CERTIFICATION

I CERTIFY THAT THE PATIENT IS UNDER MY CARE AND HAS A MEDICAL DIAGNOSIS WITH ASSOCIATED PHYSICAL / MENTAL LIMITATIONS WARRANTING THE PROVISION OF THE PERSONAL CARE SERVICES IN THE ABOVE PLAN OF CARE.

MD (SIGNATURE) — 11-10-03 (DATE)